Patient Information Form DATE:_____

Patient Name:_____

Mailing Address_____ City _____St _____Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ E-Mail:_____

Patient SS# _____ Date of Birth: _____ Sex: ☐ M or ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W Student Status: ☐ Part-Time ☐ Full-Time

Race: ☐ White ☐ Black ☐ Hispanic ☐ Native Indian ☐ Native Islander ☐ Decline to provide

Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Decline to provide

Emergency Contact:_____ Phone #_____

Guarantor Information

Guarantor Name_____ Relationship to Patient_____

Guarantor SS# _____ Guarantor Date of Birth _____

Mailing Address_____ City _____St _____Zip_____

Home Phone:_____ Work Phone:_____

Insurance Information

Primary Insurance _____ Subscriber Name_____

Subscriber Policy # _____ Group # _____

Subscriber Date of Birth _____ Subscriber SS# _____

Employer:_____ COPAY_____

Secondary Insurance _____ Subscriber Name_____

Subscriber Policy # _____ Group # _____

Subscriber Date of Birth _____ Subscriber SS# _____

Authorization for Disclosure of Protected Health Information

I authorize Victoria Orthopedic Center, LLP to Disclose Protected Health Information to the following person(s)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient or Authorized Person _____

Authorization/Notice of Privacy Practice Acknowledgement

I, the undersigned, irrevocably assign and transfer benefits to Victoria Orthopedic Center. I authorized Victoria Orthopedic Center, to file claims on my behalf and I assign insurance benefits to Victoria Orthopedic Center. If I am Self Pay, I understand I will be responsible for all charges rendered to by Victoria Orthopedic Center. I understand there will be a $35.00 returned check fee for all checks returned.
I, understand the Victoria Orthopedic Center may use and disclose my protected health information for purpose of treatment, research, payment and health care operations. I also acknowledge that I received, offered or have received in the past a copy of the Practice's Notice of Privacy Practices.

_____ Date _____

Signature of Patient or Authorized Person

PATIENT HISTORY

TODAY'S DATE:_____

Patient Name:_____ Date of Birth _____

Age _____ Height _____Weight _____ lbs. ☐ Male ☐ Female

Referring Doctor _____Primary Care Doctor_____ Cardiologist _____

Other Referring Source _____

Did this Injury occur while at work? ☐ Yes ☐ No Is this Auto Accident related? ☐ Yes ☐ No

Do you have a Lawyer for this injury? ☐ Yes ☐ No If so, Who _____

What is your primary complaint or injury? _____

How did the Injury occur? _____

Which side? ☐ Right ☐ Left ☐ Both Which is your Dominant hand? ☐ Right ☐ Left

How long have you had this problem?_____

Have you seen a Doctor for this problem? ☐ Yes ☐ No If so, Who _____

Have you seen a Pain Management Doctor for this problem? ☐ Yes ☐ No If so, Who _____

Have you had any previous surgeries to this area? ☐ Yes ☐ No If so, Who _____

MRI Taken ☐ Yes ☐ No Where? _____

X-rays Taken ☐ Yes ☐ No Where? _____

Have you been treated for this area with: ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture

☐ Cane/Walker ☐ Massage ☐ Brace ☐ Joint Injection (Steroid or Synvisc)

Current Symptoms: ☐ Pain ☐ Swelling ☐ Loss of motion ☐ Numbness/Tingling

How do you rate your pain on a scale of 0-10? (10 being worst) _____

Are you taking any medication for this problem? ☐ Yes ☐ No

☐ Ibuprofen (Motrin, Advil) ☐ Aleve/Naprosyn ☐ Tylenol ☐ Aspirin ☐ Celebrex

☐ Pain Killers (Vicodin, Lortab, Norco) ☐ Other NSAID ☐ Other

PATIENT SURGICAL HISTORY

List previous surgical operations. Have you had complications from Anesthesia? ☐ Yes ☐ No

	When	Type of Surgery	Surgeon
1			
2			
3			
4			
5			

PAST MEDICAL HISTORY

(Check the box if YES and indicate year)

	Year			Year	
☐	_____	AID/HIV	☐	_____	Migraine
☐	_____	Angina	☐	_____	Heart Attack
☐	_____	Arrhythmia (Atrial Fib)	☐	_____	Heart Murmur
☐	_____	Asthma	☐	_____	Hepatitis
☐	_____	Arthritis	☐	_____	High Blood Pressure
☐	_____	Rheumatoid	☐	_____	Hypo or Hyperthyroid
☐	_____	Balance Difficulty	☐	_____	Incontinence Bowel/Bladder
☐	_____	Blood Clots	☐	_____	Lupus
☐	_____	Pulmonary Embolism	☐	_____	Osteoporosis
☐	_____	Blood Transfusion	☐	_____	Phlebitis
☐	_____	Cancer	☐	_____	Psychiatric Disorders
☐	_____	Diabetes	☐	_____	Seizures
☐	_____	Emphysema	☐	_____	Stroke
☐	_____	Fibromyalgia	☐	_____	Tuberculosis
☐	_____	Gout	☐	_____	Walking Difficulty
☐	_____	Headaches	☐	_____	Other Please list

FAMILY MEDICAL HISTORY

	AGE	DISEASES	IF Deceased, Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Child			
Child			
Child			

SOCIAL HISTORY

Smoking Status
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Current every day smoker

Tobacco Use
- ☐ 1-9 cigarettes per day
- ☐ 10-19 cigarettes per day
- ☐ 20-39 cigarettes per day
- ☐ 40+ cigarettes per day
- ☐ Cigar smoker
- ☐ Pipe smoker
- ☐ Chews tobacco
- ☐ Snuff user

Alcohol Use
- ☐ Yes
- ☐ No
- ☐ Social
- ☐ Occasionally
- ☐ Daily Quantity?_____ Kind?_____

Drug
- ☐ Yes
- ☐ No
- ☐ Occasionally

Exercise
- ☐ Yes
- ☐ No
- ☐ Occasionally

Nutrition
- ☐ Regular Diet
- ☐ Vegetarian
- ☐ No Restrictions
- ☐ Other

Lives with
- ☐ Parents
- ☐ Siblings
- ☐ Alone
- ☐ Spouse
- ☐ Partner
- ☐ Roommate
- ☐ Children
- ☐ Other

Number in Household _____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamins, and Diet supplement products. Also list any medicine you take only on occasion like (Viagra, albuterol, nitroglycerin).

Do you have any of these allergies? ☐ Metal ☐ Latex ☐ Iodine ☐ Other _____

List any Medication allergies: _____

Pharmacy preference: _____

Pharmacy Location: _____

MEDICATION (BRAND AND GENERIC NAME)	DOSE	How Often Do You Take the Medication	Reason for Taking	Prescriber

DATE UPDATED: _____